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Original Communication

Principal forensic physicians as educational supervisors

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ABSTRACT

This research project was performed to assist the Faculty of Forensic and Legal Medicine (FFLM) with the development of a training programme for Principal Forensic Physicians (PFPs) (Since this research was performed the Metropolitan Police Service have dispensed with the services of the Principal Forensic Physicians so currently (as of January 2009) there is no supervision of newly appointed FMEs or the development training of doctors working in London nor any audit or appraisal reviews.) to fulfil their role as educational supervisors.

PFPs working in London were surveyed by questionnaire to identify the extent of their knowledge with regard to their role in the development training of all forensic physicians (FPs) in their group, the induction of assistant FPs and their perceptions of their own training needs with regard to their educational role. A focus group was held at the FFLM annual conference to discuss areas of interest that arose from the preliminary results of the questionnaire.

There is a clear need for the FFLM to set up a training programme for educational supervisors in clinical forensic medicine, especially with regard to appraisal.

1. Introduction

The overall aim of this research was to assist the Faculty of Forensic and Legal Medicine (FFLM) with the development of a training programme for Principal Forensic Physicians (PFPs) to fulfil their role as educational supervisors.

The Faculty of Forensic and Legal Medicine (FFLM) is the most recently formed Faculty of the Royal College of Physicians of London with the inaugural meeting having taken place on 13 April 2006.[1] The Faculty has been founded to achieve the following objectives:

- To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine.
- To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

One of the aims of the Faculty is to establish a training pathway in forensic and legal medicine and achieve specialist recognition of the specialty. The specialty includes doctors working as forensic physicians in general forensic medicine and sexual offence medicine.

The Metropolitan Police Service (MPS) has approximately 150 forensic physicians (FPs) working in 19 groups in London. Each group is lead by a PFP[a] with duties including managerial responsibility and an educational supervisory role – specifically to:

Supervise the development training of all the FPs in the group, giving special attention to the needs of and induction of assistant FPs, and to undertake audit and appraisal reviews as appropriate.

Ensuring trainees are competent, supervising clinical practice within clinical teams, and undertaking audit is all part of clinical governance.[2]

The specific aims of this study were to identify:

- The extent of the PFP's knowledge with regard to their role in the development training of all FPs in their group, and the induction of assistant FPs;
- How these roles may differ;
- Perceptions of the training needs of the PFPs with regard to their educational role;
- How these might best be met.

There has never been any formal training for this supervisory educational role. Forensic physicians work in the independent sector where standards vary.

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[a] Since this research was performed the Metropolitan Police Service have dispensed with the services of the Principal Forensic Physicians so currently (as of January 2009) there is no supervision of newly appointed FMEs or the development training of doctors working in London nor any audit or appraisal reviews.

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Currently all doctors who wish to work in the MPS area are required to attend an approved five-day initial training course with the recommendation that this should be followed by a practical training programme.[3] For appointed doctors continuing medical education of 24 h each year is a contractual requirement, currently not enforced, and audit and appraisal are voluntary.

PFPs come from a variety of backgrounds with regard to experience and previous training and will vary in their strengths and weaknesses, and ability to cope with an educational supervisory role. It is hoped that through the survey questions the PFPs may reflect on their knowledge, experience, skills, and limitations with regard to this role.[4] Their responses will inform future training for an educational supervisory role. To diagnose learning needs it is useful to consider what competences, the PFPs currently have and what evidence there is in relation to their current practice in this area.[5]

2. Methods

An anonymised questionnaire with a supportive letter was sent to each PFP in February 2008 (copy available from the author) and following this a focus group was convened to explore and discuss areas of interest that had arisen from preliminary evaluation of the questionnaire results.

3. Results – questionnaire

There was a 100% response rate to the questionnaire ($n = 18$) (I excluded myself). One returned answers in a prose format; four by telephone interview at their request; and 13 completed the questionnaire and returned it by mail, fax, or email. No one remained anonymous and all were willing to discuss the issues further.

At the time of the research (February 2008) the PFPs had been working in the field of clinical forensic medicine (CFM) a mean of 22 years (range 11–43 years) with the length of time as the appointed PFP varying from 6 months to 21 years (mean 8 years).

Nine PFPs were fellows or members of the FFLM and one had joined as an affiliate. One third (6/18) were approved under the Mental Health Act 1983 as having special experience in the diagnosis and treatment of mental disorder. 12/18 had received training and previously worked as sexual offence examiners and child examiners but none were currently involved in acute cases. Eight PFPs had a number of higher qualifications including FRCGP, MRCGP (x3), FRCP, MRCP, FRCS (x2), MS, MD, FACBS, DRCOG (x2), MSc, MA(Med Ed), BDS.

3.1. Development training

Nearly all groups (15/18) met regularly at least 3–6 monthly; one group yearly and one group occasionally when required. One respondent stated that the group rarely met all together but the PFP met with group members and/or spoke and/or had email contact several times a week. With regard to the format of the meetings 14/17 had some educational input; two were business only and one business/social. Nine groups (9/14) applied for approved training hours for variable lengths of time (from 1.5 to 4 h).

Five replied that they had meetings with individual doctors to discuss their personal development plan; one did this by phone and one only with assistant FPs. Eleven PFPs encouraged and reminded members of the need to attend 24 h of approved medical educational training meetings over the calendar year as per the MPS current contract.

3.2. New members

All groups except one had appointed assistant FPs (AFPs) in the past 5 years. Eight PFPs had used the practical induction training programme produced by the Association of Forensic Physicians and revised in 2008 by the FFLM[3]; a further five were aware of the existence of the programme but had not used it and four were not aware of the document.

Even where the programme was used, all PFPs who had assistant FPs to train had ensured that they were competent to work in the police station by a number of methods:

- Monitoring their case work;
- Looking at original notes and entries on forms or national computer system (NSPIS);
- Feedback from colleagues, custody officers and other police officers.

Many (10/17) ensured that the assistant FPs had shadowed the PFPs and other experienced members of the group before starting work on their own, both before, and after the currently compulsory residential training course.

3.3. Appraisal in clinical forensic medicine (CFM)

Nine PFPs (50%) were trained appraisers but only two had been appraised in CFM specifically and these two had appraised members of their own group. With regard to who should be doing the appraisals, opinion was divided with a third of PFPs agreeing that they should appraise members of their own group and with one doctor commenting that a second opinion should be obtained if there were concerns. However one third felt that appraisals should be performed by an independent appraiser. Three doctors thought both systems would be satisfactory and one had no view. One PFP was unsure of the benefits of appraisal, feeling that it did not improve practice and was a waste of money, and another felt that further discussion was required on this issue.

3.4. Audit

Ten groups had been involved in audit and 14 examples were given of audits that had been carried out within groups:

- Response times.
- Calls per month.
- Percentage of detainees sent to hospital.
- Review of constant supervision requests by different doctors.
- Hospital admission rates and reasons.
- Case type.
- Regular reviews of workload.
- Drink drive examination.
- Analysis of smokers and illness.
- Analysis opiate substitution treatment.
- Time response for drinking driving cases.
- CS pray usage.
- Deaths in custody.
- Mentally disordered detainees arrested in a six moth period.

When asked about awareness of the contract requirement of PFPs (two PFPs did not answer this question):

15/16 were aware of the requirement to supervise the development training of all the FPs in the group.

15/16 were aware of the requirement to supervise the training needs of and induction of assistant FPs.

12/16 were aware of the requirement to undertake audit as appropriate.

9/16 were aware of the requirement to undertake appraisal reviews as appropriate.

50% of the PFPs felt that they met the contractual requirements above, however two of these commented that they did not

undertake appraisals. A third (6) responded that they felt they did not meet the contractual requirements. One was unsure.

Factors given as preventing the PFPs from doing this were:

- Lack of time and resources, including financial support (5).
- The perceived need to be trained in exactly what is necessary (2), lack of knowledge of role (2), including as an appraiser (1).
- There is no organised system of appraisal (1).
- Lack of management authority of the PFPs over the assistant FPs and FPs in their group – "cannot tell group members what to do" (1).
- Lack of forensic awareness of some doctors and the general professional commitment of group members who are not career forensic physicians but GPs who see the post as a way of earning money (1).
- Lack of support from senior police in managing groups (1).
- The police's lack of perception of support required for the CFM service (1).

Further general comments were made over the uncertainty regarding the future of the service in London; the general lack of development in the field of CFM, especially with regard to academic appointments and specialist status; and the failure of development of a career structure.

3.5. Perceived need for training and support

All PFPs who replied (17/18) felt competent to perform the contractual requirements outlined above but 30% felt that they had not had enough training to perform the role of the PFP. This is an interesting result as those who feel they are competent should also feel that they have had sufficient training but this may reflect slightly ambiguous questions regarding the contractual requirement and the overall role of a PFP. Comments were made about the lack of training and the need to outline the responsibilities of PFPs.

Every three months a meeting is hosted by the police authorities at a central London location where all 19 PFPs can attend to discuss matters of interest to the doctors and the police. Most PFPs attended these quarterly meetings but, significantly, 50% (9) felt that the meetings did not provide enough support.

Comments were made on how the meetings could be improved including:

- Agenda and issues should be set by PFPs.
- Need more general medical input rather than just forensic issues.
- More time with doctors only present, rather than MPS management.
- Content too political with no educational input making meetings a waste of time.
- Should promote better intergroup back-up network.
- Useful for information sharing but does not address the day-to-day difficulties of being a PFP due to deficiencies in the current contract which does not give adequate responsibility and peer support in dealing with problems with fellow FPs.
- Likelihood of new contract with no PFP role in the future.
- Need for MPS management to listen to concerns and suggestions and provide more support for PFPs but currently the meeting is a waste of time as it has no real purpose or benefits.

There was an overwhelming need (15/16) for PFPs to be supported with regard to their personal development needs and appraisal. Most felt that the Faculty should do this with some input from the MPS.

4. Focus group discussion

A focus group was run at the annual conference of the FFLM. The session was timed for 1 h and 21 people attended from different parts of the country. As moderator I outlined the background to the research and suggested four areas of interest for discussion that had arisen from evaluation of the responses to the questionnaire: appraisal; initial training for newly appointed FPs; developmental training for all FPs; and who should be the trainers?

Themes that arose from the focus group discussion included.

4.1. Appraisal

- Appraisal is not performed specifically in CFM in any official capacity and the group felt there was a need for a separate appraisal process (separate to general practice or other areas of the doctor's work).
- The urgent need for trained appraisers was highlighted and the Faculty was asked to consider organising a training course for those interested in becoming appraisers.
- Funding was going to be required.

4.2. Training for newly appointed FPs

- Most attendees were involved in non-accredited initial training in-house for newly appointed FPs. There was evidence of evaluation of these courses. There was some knowledge of accredited Faculty/NPIA course but not all doctors could be sent on these courses because of restricted funds and time commitment.
- There was some knowledge of the FFLM Sexual Offence Medicine and General Forensic Medicine practical induction programmes but not all were using these training packages.
- Most attendees who were responsible for training used direct supervision, 'shadowing', a log book and peer support, followed by continuing telephone support, ongoing peer group meetings.

4.3. Development training

- Attendees felt this should include regular peer group meetings – to include peer review where appropriate.
- Joint training was highlighted as very important where multidisciplinary practice occurs (FPs working with custody nurses and paramedics).
- Continuing medical education (content unspecified) of 50 h was felt to be minimum requirement.
- Regular audit should be performed.

4.4. Who should train?

- Individuals should have a certain length of experience.
- Qualifications were felt to be important and there were comparisons with the Royal College of General Practitioners and a requirement for Membership exam (MRCGP) but a number thought that lack of qualifications per se should not preclude individuals from training.
- All felt that trainers needed to demonstrate a commitment to CME with evidence of an up-to-date portfolio.

5. Discussion

5.1. Strengths and limitations of the study

This research project generated a huge amount of interest from colleagues. The 100% response rate from the PFPs to the questionnaire, all of whom volunteered to discuss the issues further, is an excellent result. The research was carried out with great

uncertainty over the future role of the PFPs in London. The uncertainty with regard to the future of CFM service provision is a nationwide problem and therefore the large number of doctors who attended the focus group is also very encouraging.

There are a number of limitations to this study which include that the sample size for the questionnaire survey was small and not all the questionnaires were fully completed. The sample surveyed concerned PFPs in London only. The focus group was really too big for all in the group to participate in the discussion and ideally a focus group should consist of 4–12 participants[6] providing ideas and views that are less accessible in a one-to-one interview.[7]

In the initial project outline follow-up interviews were proposed with three PFPs to discuss issues arising from the questionnaire. These were not done as in May 2008 the MPS announced that the role of the PFPs was no longer required and contracts were terminated as from the end of September 2008. To interview three PFPs could possibly have introduced a negative bias and so this part of the research methodology was abandoned.

Mays and Pope[8] have outlined ways of improving validity in qualitative research and these include triangulation and reflexivity. Triangulation compares the results from two or more different methods of data collection in this case the results from the questionnaire survey and focus group discussions.

Reflexivity means the sensitivity to the ways in which the researcher and the research process have shaped the collected data. In this project bias may have been introduced because of the researcher's (my) familiarity with the PFPs replying, the Hawthorne effect.[9] Lingard and Kennedy[10] outline issues such as the subjectivity of the researcher and the emotionality of the research participants which need to be recognised and appropriately managed although this was a difficult area to manage in this research as the circumstances of the PFPs changed during the time of the research project.

Certainly the ethical issues of informed consent, confidentiality and anonymity must be considered with any research.[11] Although all participants chose not to be anonymous when responding to the questionnaire, their anonymity was assured in the final results, as replies and comments are not attributable any individual participant.

5.2. Educational supervision

This study is the first to consider the role of PFPs as educational supervisors. Supervision has three functions: educative; supportive; and managerial/administrative (including patient management). Doctors working as educational supervisors need to have good interpersonal and teaching skills, be clinically competent and knowledgeable.[12]

However the practice of educational supervision is variable within the NHS.[13] Certainly within the field of CFM little is known about how educational and clinical supervision is provided for doctors working within the field at any stage of training and personal development.

The General Medical Council states that doctors must make sure that the staff for whom they are responsible are properly supervised.[14] This includes taking part in audit, performing appraisal, and assessing the performance of colleagues. Working as a manager a doctor needs to be able to lead a team effectively offering help to those they manage when they need it.[15] The GMC has clear guidance for doctors with regard to their responsibilities in relation to supervision and managerial responsibilities.[14–16]

Although FPs work outside the NHS in the independent sector, standards of training should be comparable to that within the NHS where educational supervision is mandatory.[17,18] It is important to assess educational supervisors' opinions about their roles and their ability to fulfil such roles.[19] Durguerian et al.[20] have previously shown that NHS consultants need specific training for their role as educational supervisors.

In this survey nearly all PFPs were aware of their contractual requirements to supervise development and induction training of FPs. The inherent difficulties in being responsible for their peers' training were highlighted as a particular issue. Most PFPs felt competent to perform their contracted role but there was a perceived need for the responsibilities to be outlined and training and support to be provided especially with regard to appraisal. Time and resources are required for formal training in educational supervision.[21] Many of the PFPs in London are involved in three types of supervision[22]: on-the-job; one-to-one; and peer group meetings where cases may be discussed looking at different ways of practising and coping. The system of shadowing experienced doctors is widely used in CFM but such teachers need to be enthusiastic for this role and able to effectively communicate with learners.[23]

The supervisor may need at different times to take on a variety of roles including advisor, role model teacher and facilitator.[24] Training needs to reflect these differing roles and there needs to be a forum to support doctors working as educational supervisors.[25] A study looking at the views of specialist registrars in training has highlighted the importance of committed educational supervisors.[26]

6. Conclusions

This study shows that Principal Forensic Physicians within the Metropolitan Police Service are working as educational supervisors, involved in educational initiatives, training, audit, and appraisals. These are all key components which effectively combine to make up good clinical governance.[27]

A recent report[28] has stated that there is no evidence of clinical governance in certain MPS areas and the authors recommend that "there should be clinical governance arrangements that include the management, training, supervision and accountability of staff". This has been a contractual requirement of the PFPs in London and whilst the practice in London may be variable this research has confirmed that there has been little recognition and managerial support from the police authorities for this role. The recent decision of the MPS to dispense with the current PFP contract for services means that the authorities will need to put in place robust procedures to deal with clinical governance in the future if they are to fulfil their international obligations for the care of detainees in police custody in London.

The Faculty of Forensic and Legal Medicine has been created to ensure the highest professional standards of competence and ethical integrity. There is a clear need for the FFLM to set up a training programme for educational supervisors in clinical forensic medicine, especially with regard to appraisal. Supervision needs to be planned and structured but supervisors need to have the appropriate training and skills to be effective and promote trainees' learning.[29]

Conflict of Interest

None declared.

Funding

None required/received.

Ethical approval

Considered an audit.

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